Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

______________________________ ____/____/____
Name of Facility/School Today's Date

______________________________ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine ______________________________

Reason medicine is needed during school hours ______________________________

Dose ______________________________ Route ______________________________

Time to give medicine ______________________________

Additional instructions ______________________________

Date to start medicine _____/_____/_____ Stop date _____/_____/_____

Known side effects of medicine ______________________________

Plan of management of side effects ______________________________

Child allergies ______________________________

PRESCRIBER'S INFORMATION

____
Prescribing Health Professional's Name

____
Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

____
Parent or Guardian Name (Print)

____
Parent or Guardian Signature

____
Address

____
Home Phone Number Work Phone Number Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child ____

Name of medicine ____

Date medicine was received _____/_____/_____

Safety Check

☐ 1. Child-resistant container.

☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Child Health Record is on file.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

____

Caregiver/Teacher Name (Print)

____

Caregiver/Teacher Signature

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child ______________________________ Weight of child______________

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________
Dosage/amount					
Route					
Staff signature					

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	**Error/problem/reaction to medication**	**Action taken**	**Name of parent/guardian notified and time/date**	**Caregiver/teacher signature**

	Date	Parent/guardian signature	Caregiver/teacher signature
RETURNED to parent/guardian	/ /		
	Date	Caregiver/teacher signature	Witness signature
DISPOSED of medicine	/ /		